PROVIDENCE
Health & Services

January 26, 2016

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

Re: Comments on the Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of Providence Health & Services, thank you for the opportunity to provide feedback to the U.S. Senate Finance Committee Bipartisan Chronic Care Working Group Policy Options Document offering proposed policy changes to improve the delivery and financing of care for chronically ill Medicare beneficiaries.

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. The comprehensive scope of services at Providence includes 34 hospitals, 475 physician clinics, home health and hospice, senior services, supportive housing and many other health and educational services. The health system and its affiliates employ more than 76,000 people across five states: Alaska, California, Montana, Oregon and Washington.

As a large, integrated health care system providing services to patients across the continuum of care – from primary to acute care to home health and hospice – we are committed to clinical excellence with compassion. We know that quality of life improves when individuals and families have broad access to high-quality, patient-focused, affordable care. Together, Providence ministries and secular affiliates are working at scale to improve overall health in every community we serve through innovation in care delivery, new economic models and expert-to-expert collaboration.

General Comments:
We commend the Finance Committee for establishing the Chronic Care Working Group and its year-long process to gather stakeholder perspectives to shape important policy changes for the Medicare program. The Policy Options Document offers a series of constructive recommendations that if individually adopted would make important improvements to care for chronically ill beneficiaries served through Fee-For-Service Medicare, accountable care organizations, and Medicare Advantage. However,

we are concerned that the cumulative effect of these policy changes, without a mechanism to align them together, would potentially create further fragmentation of care and add to the burden on providers to design systems and structures to effectively provide chronic care management to large populations of beneficiaries. For example, currently providers participating in the Medicare Shared Savings Program are not able to participate in the Independence at Home demonstration (if expanded), or the Comprehensive Primary Care initiative (CPCi) due to the shared savings component of each model.

Additionally, if the originating site geographic restrictions for Medicare coverage of telehealth services are waived for ACOs, we ask that it be explicit that ACO providers may offer telehealth services to all beneficiaries they serve, not just those assigned to the ACO.

Providence recommends that Congress eliminate the beneficiary cost-sharing for the chronic care management codes that CMS put into effect in 2015. These new codes provide an important per beneficiary, per month chronic care management fee that in theory will provide reimbursement targeted to chronically ill beneficiaries that would allow providers the flexibility to coordinate the range of services needed to effectively deliver the range of services needed by individuals with multiple chronic conditions. However, the administrative burden of these new codes is very high and the cost sharing required as a Part B benefit creates barriers for patients signing up for these high-value services.

We recommend that Congress identify mechanisms to create greater alignment across the various alternative payment models so that providers can participate in different models concurrently for the highest risk populations. Allowing providers to participate in multiple delivery models, while creating one, valid shared savings calculation for the organization would give providers the ability to better deliver the specific services needed by beneficiaries based on their location, health status and social situation.

Below are Providence Health & Services' specific recommendations on policy changes under consideration by the Working Group:

Expanding the Independence At Home demonstration

The working group is considering expanding the current IAH demonstration into a permanent, nationwide program. In addition, the working group is considering modifications to the program, including using hierarchical condition categories (HCC) risk scores as a way to identify complex chronic care beneficiaries in IAH instead of requiring that the individual undergo a non-elective hospitalization within 12 months of his or her IAH program participation.

Providence strongly supports expansion of the IAH program with certain modifications. First, we recommend greater flexibility in the patient criteria used by providers to identify patients eligible to enroll in the program, including the use of HCC scores. We encourage the elimination of the prior hospitalization to qualify, as that criterion is a significant barrier – particularly as we seek to reduce hospitalizations. Beneficiaries should be able to enroll as they become eligible for the program at any point during the 12-month period, rather than being limited to a single enrollment period. Additionally, Providence recommends that the geographic requirements for Medicare payment for telehealth services be waived for the program so that participating providers can utilize telehealth to improve care delivery.

Improving Care Management for Beneficiaries Living With Chronic Conditions

The Working Group is considering establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. The purpose of this new code would be to reimburse clinicians for coordinating care outside of a face-to-face encounter for beneficiaries with the most complex chronic conditions. This new high-severity code would be higher to compensate providers who require more than the 20 minutes per month under the existing chronic care management fee.

While we applaud the Working Group's efforts to improve the Medicare reimbursement mechanisms to support effective chronic care management, Providence does not support the creation of a new chronic care management code, even with a higher level of reimbursement. We urge the Work Group to focus on reforming the existing chronic care management code to address the barriers to implementation. The current codes require that beneficiaries enroll in a chronic care management program, includes a separate co-payment and additional documentation, it has not been highly utilized by primary care practices to date. In our view, adding new codes creates greater complexity and administrative burden for providers to ensure accurate billing, along with adding cost-sharing for beneficiaries.

As noted above, Providence recommends that Medicare establish a chronic care management fee, utilizing the same patient criteria for qualification. This management fee could be used by the physician practice to utilize social services, integrate behavioral health and other necessary activities to support improving the health status of the chronically ill beneficiary. Examples of effective care management models include Pathways, which utilizes a team of caregivers (social workers, gerontologists, nurses) and the Program for All-Inclusive Care for the Elderly (PACE), which is provided via a capitated payment model.

This is especially critical to build incentives to provide the low-intensity, high frequency behavioral health services needed for this patient population that can be delivered within the primary care clinic setting.

The payment rate could be adjusted upward for higher severity chronic illnesses or if Alzheimer's or other dementia is present.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

The working group is considering developing policies that improve the integration of care for individuals with a chronic disease combined with a behavioral health disorder. Policies would encourage care integration whether the beneficiary is enrolled in traditional fee-for-service Medicare, an alternative payment model or Medicare Advantage plan.

Providence recommends that the Working Group consider, in the context of a Medicare chronic care management fee, allow for the utilization of the Multi-condition Collaborative Care, or TEAMcare, model.[i] This model has shown to effectively improve outcomes for patients with concurrent medical and behavioral health conditions. Allowing providers the flexibility to provide this type of holistic, team-based approach to serving chronically ill beneficiaries should be available through Fee-For-Service, Medicare Advantage and alternative payment models.

Expanding Use of Telehealth for Individuals with Stroke
The Working Group is considering eliminating the originating site geographic restrictions for the narrow purpose of promptly identifying and diagnosing strokes.

Providence strongly supports this proposal, as telestroke is rapidly becoming the new standard of care, whether for patients in rural areas or urban areas. Telestroke has been shown to improve quality and efficiency in stroke care and this proposal would result in more rapid diagnosis and treatment and improve outcomes.

Proposals to Improve Chronic Care Management in ACOs

Providing ACOs the Ability to Expand Use of Telehealth
The Working Group is considering modifying the requirements for reimbursement for telehealth services provided by ACOs in the Medicare Shared Savings Program (MSSP). In addition, the HHS Secretary would be required to establish a process by which ACOs participating in MSSP two-sided risk models may receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services.

Providence supports the relaxing of the originating site requirements for telehealth in the last two years for Track One ACOs in the Medicare Shared Savings Program as a "glide-path" toward an ACO model that includes downside risk. Because the technology for telehealth requires significant investment, waiving some or all of the geographic requirements would enable MSSP ACOs to innovate as they prepare to take on downside risk. Moreover, telehealth should not be limited to only those beneficiaries assigned to the ACO.

Providing Beneficiaries Flexibility to Be Part of an ACO
The working group is considering recommending that ACOs in the MSSP Track One be given the choice as to whether their beneficiaries be assigned prospectively or retrospectively. In addition, the working group is considering recommending that Medicare Fee-For-Service beneficiaries have the ability to voluntarily elect to be assigned to the ACO in which their main provider is participating. The Secretary would be required to establish a process by which beneficiaries could voluntarily elect to be assigned to a MSSP ACO while still retaining their freedom of choice to see any provider.

Providence supports establishing the option for Track 1 ACOs to utilize prospective or retrospective attribution/assignment of beneficiaries. This change would greatly improve ACOs' ability to coordinate care to improve quality and lower costs. We recommend that the MSSP establish that allows both prospective assignment/attribution combined with a process for retrospective reconciliation. This mechanism would allow ACOs to more accurately determine which beneficiaries start and finish the year enrolled and see network providers. This would also allow for maintenance of the freedom of choice principle, yet provide accurate accounting of beneficiaries enrolled.

Providence recommends that up-front payments proposed by the Working Group for the MSSP be limited to ACOs participating in MSSP Tracks 2 and 3, as well as the NextGen MSSP, but not for Track 1 ACOs. Because Tracks 2-3 and the NextGen MSSP models include two-sided risk, an up-front payment offers a mechanism to help spread the costs of investing in care management programs over the course of the enrollment period. However, because Track 1 ACOs are not subject to downside risk, an up-front payment would o increase administrative complexity, without adding a financial benefit to the ACO.

Eliminating Barriers to Care Coordination under ACOs

The Working Group is considering allowing ACOs in two-sided risk models to waive beneficiary cost-sharing, such as co-payments, for items and services that treat a chronic condition or prevent the progression of a chronic disease.

Similar to our recommendations regarding telehealth and prospective/retrospective assignment to ACOs, Providence recommends that the Working Group's proposal to waive beneficiary cost-sharing for items and services related to chronic care management be extended to Track 1 ACOs. Waiving cost-sharing would provide another important incentive for providers engaging these beneficiaries in managing their care. Additionally, we recommend that the items and services subject to the waiver be determined through rulemaking to ensure consistency and reduce confusion for beneficiaries.

Proposals to Improve Chronic Care Management in Medicare Advantage:

Providing Medicare Advantage Enrollees with Hospice Coverage

The Working Group is considering requiring MA plans to offer the hospice benefit provided under traditional Medicare. The full scope of the hospice benefit, including the required care team and written care plan, would be required. If a policy change is made, the current MA payment system would need to be adjusted to take into account this additional benefit. In addition, the MA five-star quality measurement system would need to be updated to include measures associated with hospice care.

Providence continues to be a strong advocate for improving the delivery and financing of palliative and end of life care. While the current policy that requires MA enrollees to receive coverage of hospice benefits separate from their MA plan is often a barrier to integration of services, we are concerned that requiring MA plans to cover the full hospice benefit could lead to reduced access to services and result in beneficiaries delaying their election of the hospice benefit.

Because election of the hospice benefit requires that a beneficiary forego curative treatment, we are concerned that MA enrollees would delay their election as long as possible; moreover, because the MA plans will be responsible for the total cost of care, if hospice costs are not accurately captured in the MA benchmark it is likely that reimbursement would be lower for hospice providers, potentially jeopardizing access for beneficiaries.

Providence instead supports Congress establishing a hospice model that would extend the Medicare Care Choices demonstration to allow MA and MA-Prescription Drug (MA-PD) plans the option to offer hospice benefits concurrently with curative care to plan enrollees. This option under MA would provide more flexibility and cost savings to plan enrollees. As part of such a model, we recommend CMS monitor the following metrics: hospice length of stay; impact on acute, intensive care unit and emergency room utilization; impact on medical cost; and member and family satisfaction (through Family Evaluation of Hospice Care (FEHC) or similar survey instrument). We also emphasize that a model include the study of utilization of all services in the hospice population, particularly those services deemed "curative."

Finally, we believe that MA plans that elect to include hospice care should expand the eligibility requirement of a six months prognosis to a twelve month prognosis. This change would better represent current end-of-life care standards.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Beneficiaries
The chronic care working group is considering allowing MA plans to offer a wider array of supplemental benefits than they do today. These additional supplemental benefits could be medical services or other non-medical, social services that improve the overall health of individuals with chronic disease. Any new supplemental benefits would continue to be paid by plans' rebate dollars.

Providence supports the Working Group proposal to allow MA plans to offer a wider array of supplemental benefits to more effectively serve chronically ill beneficiaries. Providing MA plans with the flexibility to offer home-based services for enrollees who are not completely home bound, nutrition counseling and support and reduced cost-sharing for drug costs for enrollees with chronic conditions would be a positive addition to MA benefits. The Working Group should study the experience of the PACE program and Medicare Special Needs Plans (SNPs) to evaluate the evidence base for determining which benefits are eligible for inclusion as supplemental benefits.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth
The Working Group is considering permitting MA plans to include certain telehealth services in its annual bid amount. The use of these technologies would not be used as a substitute to network adequacy requirements.

Providence supports allowing MA plans to include telehealth services in its annual bid amount and corresponding waiver of the originating site geographic restrictions under Fee-For-Service Medicare. This change would allow MA plans to offer telehealth services universally for their enrolled population. Providence supports including telehealth services that are medically necessary and supported by evidence-based medical criteria, and do not duplicate or supplant health services that are available to the patient in person.

Thank you for the opportunity to provide our specific comments on the Working Group Policy Document. We look forward to working with the members of the Working Group as these proposals are further refined and are developed into legislation by the Finance Committee. Please contact Steve Brennan, Director, Public Policy & Research, at Steven.Brennan@providence.org if you have any questions.

Sincerely,

Rod Hochman, M.D.
President and Chief Executive Officer
Providence Health & Services

[i] "TEAMcare: An Integrated Multicondition Collaborative Care Program for Chronic Illnesses and Depression." Journal of Ambulatory Care Management, Issue: Volume 34(2), April/June 2011, p 152–162